Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-197	A. BUILDING: ______ B. WING ______	R 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KYSEEM'S UNITY GROUP HOME, LLC #3	404 WEST DEAN STREET WILSON, NC 27893

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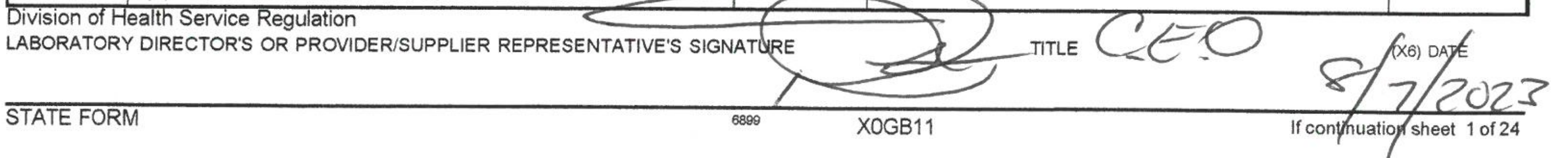
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on July 20, 2023. The complaint was substantiated (intake #NC00204415). Deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110	RECEIVED AUG 11 2023 DHSR-MH Licensure Sect	



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V 110	Continued From page 1 (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of three audited paraprofessional staff (#2) demonstrated the knowledge, skills, and abilities required by the population served. The findings are: Review on 07/18/23 of client #2's record revealed: - 26 year old male. - Admission date of 03/11/22. - Diagnoses of Selective Mutism, Post Traumatic Stress Disorder, Autism Spectrum Disorder, Schizophrenia and Lactose Intolerance. Review on 07/18/23 of client #2's Individual Support Plan dated 10/01/22 revealed: - "Things that may create stress. Situations where I'll need extra help? Loud noises Not having quite time when at the group home being around a crowd People going into his room without permission..." - "What is not working?...[Client #2] is a very private person. [Client #2] does not want anyone in his room..." Review on 07/19/23 of staff #2's record revealed: - Date of hire: 09/21/21.		KUGH acknowledges that all paraprofessional staff must demonstrate the knowledge, skills, and abilities required for the population we serve. For the staff identified in this report, we have completed a in-service training and competencies for each resident in the home he works. Going forward, annually, all staff will receive an updated training on the knowledge, skills, and abilities required to work with clients in their assigned facility. As new residents are admitted, this training will take place within 30 days of their admission. Quarterly, our QA/QI staff will review all staff records to ensure that the competencies and in-service sheets are in the records. This will be matched to the current census of each home during this review. Any areas of deficiency will be addressed by the Qualified Professional during monthly staff meeting and the agency owner. Annually, during performance evaluations, staff records will be reviewed to ensure the information is current to residential census.	9/18/2023

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V 110	Continued From page 2 - Client rights and cultural competency training 06/23/23 - No signed client specific training for client #2.. Interview on 07/18/23 client #2 stated: - He had lived at the facility for one year. - He lived in the bedroom downstairs. - Staff #2 was a weekend staff. - Staff #2 had made sexual comments about my appearance. - Staff sleep at the facility - Staff #2 has come in his room with boxer shorts on. Interview on 07/19/23 staff #2 stated: - He worked at the facility for two years. - He worked Friday, Saturday and Sunday nights. - He knows client #2 does not like people in his room. - He has gone thru client #2's room to shower. - He had gone in to client #2's bedroom without a shirt to get to the staff bathroom. - "We are all men. I go in and shower and wash up." Interview on 07/18/23 and 07/19/23 the Licensee stated: - Client #2 dressed in women's clothing. - He was not told staff #2 walked in client #2's bedroom without a shirt on or while wearing boxer shorts. - He would address the issues with staff #2.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN	V 111		

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V 111	Continued From page 3 (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure an admission assessment was completed for one of three (#3) clients. The findings are:	V 111	KUGH acknowledges that all clients must have an admission assessment for all client admitted to a home/facility. For the client identified in this report, the admission assessment has been added back to the record.	9/18/2023

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V 111	Continued From page 4 Review on 07/18/23 and 07/19/23 of client #3's record revealed: - 37 year old male. - Admission date of February 2023. - Diagnoses of Autism Spectrum Disorder, Severe Intellectual Developmental Disability and Seizure Disorder. - No facility admission assessment. Interview on 07/19/23 the Licensee stated: - He was aware an admission assessment had to be completed for each new admit prior to the delivery of services. - He would ensure clients have an admission assessment.	V 111	The qualified professional, QA/QI and agency owner will review all records for each home to ensure no other admission assessments are missing from the permanent record. Quarterly, as new residents are admitted, the QA/QI and qualified professional will complete a record review to ensure a complete record for each client is in place.	9/18/2023
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address	V 113		

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V 113	Continued From page 5 and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician affecting two of three clients audited (#2 and #3). The findings are: Review on 07/18/23 of client #2's record revealed: - 26 year old male. - Admission date of 03/11/22. - Diagnoses of Selective Mutism, Post Traumatic Stress Disorder, Autism Spectrum Disorder,		KUGH acknowledges that all clients in its program must have a signed statement from the client or their legally responsible person granting permission to seek emergency care from a hospital or physician. For the two clients in this report, our form seeking this permission has been given to the legally responsible persons and once received, will be added to the permanent record of each client admitted into our program.	9/18/2023

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V 113	Continued From page 6 Schizophrenia and Lactose Intolerance. - No signed consent for emergency treatment. Review on 07/18/23 and 07/19/23 of client #3's record revealed: - 37 year old male. - Admission date of February 2023. - Diagnoses of Autism Spectrum Disorder, Severe Intellectual Developmental Disability and Seizure Disorder. - No signed consent for emergency treatment. Interview on 07/19/23 the Licensee stated: - He was aware an emergency consent should be signed by each client's guardian. - He would follow up on the authorizations for emergency treatment.	V 113	To address this globally, we will complete a peer review of all admitted clients in our homes to make sure this form is in place to seek emergency treatment as needed. Quarterly, our QA/QI staff will pull a random sample of any newly admitted clients to ensure we have the consent to seek emergency treatment in the record. Any deficiencies will be reported to the qualified professional and agency owner.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

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V 114	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 07/19/23 of facility records from October 2022 thru June 2023 revealed: - No 2022 4th quarter fire drills documented for the weekend 8am to 5pm shift or the weekend 5pm to 8am shift. - No 2022 4th quarter disaster drills documented on the weekend 5pm to 8am shift. - No 2023 1st quarter fire drills documented for the weekend 8am to 5pm shift or the weekend 5pm to 8am shift. - No 2023 1st quarter disaster drills documented on the weekend 5pm to 8am shift. - No 2023 2nd quarter fire or disaster drills documented for the weekday 5pm to 8am shifts. Interview on 07/18/23 client #2 stated he participated in fire and disaster drills. Interview on 07/18/23 the Licensee stated: - The facility had three shifts. - Weekday shift was 5pm to 8am. - Weekend shift was 8am to 5pm and 5pm to 8am. - He was aware fire and disaster drills should be completed on each shift every quarter. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	KUGH acknowledges that al facility must ensure that fire and disaster drills are completed at least quarterly and repeated on each shift. To eliminate the gaps from occurring, we have a developed a drill schedule to address fire, natural disaster, bomb threats, workplace violence, and medical emergency drills. The schedule is organized by shift and location to ensure that each shift complete all drills at least twice every 6 months. With the qualified professional, these drills will be reviewed monthly to ensure it matches the schedule and the required drill took place based as directed. Staff will receive a refresher training on August 12th to ensure they understand how to complete drill and the required documentation. Quarterly, the QA/QI staff will summarize and analyze all drills for that quarter and submit to the agency owner to address any areas of deficiency.	8/19/2023
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS	V 118		

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V 118	Continued From page 8 (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications as ordered and maintain a current MAR for two of three clients (#2 and #3). The findings are:		KUGH acknowledges that all clients are to be administered their medications as ordered and maintained a current MAR for all.	9/18/2023

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V 118	Continued From page 9 Finding #1: Review on 07/18/23 of client #2's record revealed: - 26 year old male. - Admission date of 03/11/22. - Diagnoses of Selective Mutism, Post Traumatic Stress Disorder, Autism Spectrum Disorder, Schizophrenia and Lactose Intolerance. Review on 07/18/23 and 07/19/23 of client #2's signed FL-2 dated 04/25/22 revealed: - Vitamin D3 (treats vitamin D deficiency) 1000 units - take once daily. - Lactase (treats lactose intolerance) 3000 units three times daily. Review on 07/18/23 and 07/19/23 of client #2's June 2023 and July 2023 MARs revealed: June 2023 - Lactase (Lactaid) and Vitamin D3 administered daily per staff initials. July 2023 - No transcribed entry for Lactase and Vitamin D3. Interview on 07/18/23 client #2 stated he received his medications daily to include Vitamin D3. Finding #2: Review on 07/18/23 and 07/19/23 of client #3's record revealed: - 37 year old male. - Admission date of February 2023. - Diagnoses of Autism Spectrum Disorder, Severe Intellectual Developmental Disability and Seizure Disorder. Review on 07/18/23 of client #3's medication	V 118	KUGH will review all MARs to ensure they are all current for each resident in the home. Staff will receive refresher training on administering medications and the required documentation. Staff will be instructed to contact the qualified professional and/or agency owner, if they see no medications administered when they come on shift. This will be the checks and balance for the staff. Going forward, the qualified professional will review all MARs at least weekly to ensure that there are no gaps or sections were no medications were listed as administered. At the end of the month, the agency owner and QA/QI will gather the MARs to summarize and analyze for performance improvement. It is our goal to go to an electronic medication administration system that will prompt the users and administrators when medications have not been administered.	

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V 118	Continued From page 10 orders dated 03/27/23 revealed: - Ativan (Antianxiety) 2 milligrams (mg) - take three times daily. - Buspirone (Antianxiety) 15 mg - take twice daily Interview on 07/19/23 the Licensee stated: - He knew the MARs had to be current. - The pharmacy representative stated the current order for Vitamin D3 and Lactase had expired. - The pharmacy should have requested a refill. - He was going to switch back to his previous pharmacy.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to obtain drug regimen reviews for 3 of 3 clients (#1, #2, and #3) who received psychotropic medications. The findings are:	V 121	KUGH acknowledges that for all clients who receive psychotropic drugs, we are responsible for obtaining a review of each client's drug regimen at least every six months. We will use a pharmacist going forward to keep us in compliance.	9/18/2023

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V 121	Continued From page 11 Review on 07/18/23 and 07/19/23 of client #1's record revealed: - 37 year old male. - Admission date 01/07/22. - Diagnoses of Severe Intellectual Developmental Disability and Autism Spectrum Disorder. - No 6 month drug regimen review. Review on 07/18/23 of client #1's current drug regimen revealed: Amlodipine (treats angina) Ariprazole (antipsychotic) Depakote (treats seizures) Luvox (treats Obsessive Compulsive Disorders) Lorazepam (antianxiety) Seroquel (antipsychotic) Stool Softner Trazodone (antidepressant) Review on 07/18/23 of client #2's record revealed: - 26 year old male. - Admission date of 03/11/22. - Diagnoses of Selective Mutism, Post Traumatic Stress Disorder, Autism Spectrum Disorder, Schizophrenia and Lactose Intolerance. - No 6 month drug regimen review. Review on 07/18/23 of client #2's current drug regimen revealed: - Buspirone (antianxiety). - Quetiapine (antipsychotic) - Trazodone. Interview on 07/19/23 the Licensee stated: - He had switched pharmacies recently. - The previous pharmacy had no provided the 6 month drug regimen reviews. - He knew clients were required to have a 6	V 121	We will be working with a current pharmacist to bring the current client records into compliance. Going forward, we will get on schedule with a pharmacy to ensure this completed in July and December of each year. The qualified professional and agency owner will ensure this process takes place and is properly documented for review. The reviews will be placed in the permanent client records. Any areas of deficiency will be reported to the QA/QI staff to summarize and ensure the areas are brought back into compliance.	

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V 121	Continued From page 12 month drug regimen review for psychotropic medications.	V 121		
V 502	27D .0102 Client Rights - Suspension and Expulsion 10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility. (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: (1) the specific time and conditions for resuming services following suspension; (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and (3) the discharge plan, if any. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a client (#2) was free of threat or fear of unwarranted expulsion from the facility. The findings are: Review on 07/18/23 of client #2's record revealed: - 26 year old male. - Admission date of 03/11/22.	V 502	KUGH understands and acknowledges that clients must be free from the threat or fear of unwarranted suspension or expulsion from the facility. We will follow our existing policy for suspensions and expulsions. We will make every effort to identify an alternative service to meet the client's needs and a plan for discharge as applicable. This will be shared with the referral source upon admission.	9/18/2023

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	MHL098-197	A. BUILDING: ______ B. WING ______	R 07/20/2023

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V 502	Continued From page 13 - Diagnoses of Selective Mutism, Post Traumatic Stress Disorder, Autism Spectrum Disorder, Schizophrenia and Lactose Intolerance. Interview on 07/18/23 and 07/19/23 the Licensee stated: - He told client #2's Care Coordinator his had a policy for emergency discharges. - He told client #2's Care Coordinator he was going to emergency discharge client #2 because of a complaint from the state agency. - He had gotten upset a complaint had been generated against the facility. - He understood clients have a right to be free from unwarranted discharges or threats to discharge. - Client #2 had already planned to be discharged and he would not emergency discharge client #2.	V 502	We will review our policy on suspensions and expulsions with our staff and our policy on emergency discharges. Going forward, we will update our client handbook and have this information discussed with the referral source and legally responsible person for any potential admission. We will not discharge any client without following our policy and prescribed regulations on suspensions and expulsions. QA/QI staff will work with all guardians and legally responsible persons on any unplanned or emergency discharges. They will be advised on their rights and it will be stressed that they know they are free from the fear of unwarranted suspensions and expulsions.	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training	V 536		

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V 536	Continued From page 14 based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing	V 536		

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V 536	Continued From page 15 means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and	V 536		

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V 536	Continued From page 16 (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		

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V 536	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure three of three staff (#1, #2 and #3) received annual training updates in alternatives to restrictive interventions. The findings are: Review on 07/19/23 of staff #1's record revealed: - Date of hire: 08/01/21. - National Crisis Interventions Plus (NCI+) training updates in alternatives to restrictive interventions expired effective 06/05/23. - No current training updates in alternatives to restrictive interventions. Review on 07/19/23 of staff #2's record revealed: - Date of hire: 09/21/21. - NCI+ training updates in alternatives to restrictive interventions expired effective 05/09/23. - No current training updates in alternatives to restrictive interventions. Review on 07/18/23 of staff #3's record revealed: - Date of hire: 03/15/17. - NCI+ training updates in alternatives to restrictive interventions expired effective 02/09/23. - No current training updates in alternatives to restrictive interventions. Interview on 07/19/23 the Licensee stated: - He was aware staff were required to have current training updates in alternatives to restrictive interventions. - He had called the trainer to provide the updated training for the staff today.	V 536	KUGH acknowledges that all staff must complete annual training updates in alternatives to restrictive interventions. We have contacted our vendor to send over the updated trainings and these will be added to the staff records. We will complete a record review of all staff to ensure that no other staff are missing this critical training update. We will contact our vendor if any staff chart shows a deficiency for alternative to restrictive interventions trainings. Going forward, the QA/QI will complete a sample of the records of all staff to review for this training. Any areas of deficiency will be reported to the qualified professional and agency owner to correct.	9/18/2023

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V 537	Continued From page 18	V 537		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to	V 537		

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V 537	Continued From page 19 Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the	V 537		

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V 537	Continued From page 20 need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once	V 537		

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V 537	Continued From page 21 annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure three of three staff (#1, #2 and #3) received annual training updates in seclusion, physical restraint and isolation time-out. The findings are: Review on 07/19/23 of staff #1's record revealed: - Date of hire: 08/01/21. - National Crisis Interventions Plus (NCI+) training in seclusion, physical restraint and isolation	V 537	KUGH acknowledges that all staff must complete annual training updates in seclusion, physical restraint and isolation time-out. We have contacted our vendor to send over the updated trainings and these will be added to the staff records. We will complete a record review of all staff to ensure that no other staff are missing this critical training update. We will contact our vendor if any staff chart shows a deficiency for alternative to restrictive interventions trainings. Going forward, the QA/QI will complete a sample of the records of all staff to review for this training. Any areas of deficiency will be reported to the qualified professional and agency owner to correct.	9/18/2023

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V 537	Continued From page 22 time-out. expired effective 06/05/23. - No current training in seclusion, physical restraint and isolation time-out. Review on 07/19/23 of staff #2's record revealed: - Date of hire: 09/21/21. - NCI+ training in seclusion, physical restraint and isolation time-out. expired effective 05/09/23. - No current training in seclusion, physical restraint and isolation time-out. Review on 07/18/23 of staff #3's record revealed: - Date of hire: 03/15/17. - NCI+ training in seclusion, physical restraint and isolation time-out. expired effective 02/09/23. - No current training in seclusion, physical restraint and isolation time-out. Interview on 07/19/23 the Licensee stated: - He was aware staff were required to have current training in seclusion, physical restraint and isolation time-out. - He had called the trainer to provide the updated training for the staff today.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:	V 736	KUGH acknowledges that the facilities must be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. We will be working with our landlord to ensure that the property is updated and kept in order.	8/19/2023

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V 736	Continued From page 23 Observation on 07/18/23 at approximately 2:00pm revealed: - An ant/roach bait trap on the kitchen counter, in the food pantry and behind the refrigerator. - The kitchen floor had bits of debris on the surface. - The stairway walls had pieces of paint popping off the walls. - No light bulb globe on the overhead light at the bottom of the stairs. - Client #2's bedroom had a bent curtain rod over the window. - Client #3's bedroom had a cracked window and 2 bent curtain rods. - The upstairs bathroom had broken edges. - Client #1's bedroom had writing all over the walls. Observation on 07/19/23 at approximately 9:30am of client #3's room revealed pieces of glass on the floor near the window. Interview on 07/19/23 the Licensee stated: -He had client #3's window repaired 07/18/23. - He had been told by staff #1 the glass was on the floor. - He did not know why staff #1 did not clean up the glass. - He did not have any questions regarding facility issues identified at exit. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	Staff will receive training on 8/12/2023 to address the cleanliness of each home and their duties to help the clients maintain the home. We will implement a shift cleaning list that must be completed by staff during their working hours. These must be turned in with their time cards. We will also supply each home with a self-checklist that must be completed weekly. Any areas such as light bulbs that need to be replace will be reported to the qualified professional and agency owner. Any major areas will be reported to the landlord to repair. The agency owner will review each room and ensure bent curtain rods are replaced. The agency owner will work with the landlord on the bathroom with broken tile edges. The agency owner and staff will use the appropriate products to remove writing on the walls.	